TRIANGLE NEUROPSYCHOLOGY SERVICES, PLLC
3310 Croasdaile Drive, Suite 400, Durham, NC 27705
1540 Sunday Drive, Suite 200, Raleigh, NC 26707

Patient Name: First: _____ Date of Birth: _____ Date Completed: _____

Who referred you to our office? How did you hear about us?

What are your current concerns? What is the reason you are requesting this evaluation?

When did you first become concerned about these difficulties?

Is this your first evaluation?

If not, when were you previously assessed?

What diagnoses were provided?

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

Family History:

Mother Name: _____ Age: _____
Education: _____ Occupation: _____

Father Name: _____ Age: _____
Education: _____ Occupation: _____

Parents are:
☐ Married ☐ Separated ☐ Divorced ☐ Unmarried ☐ Remarried
☐ Widowed ☐ Deceased

Who has legal guardianship of the child? _____

Child is:
☐ Biological ☐ Adopted (at age ____) ☐ Foster

Siblings (name and age):		**Others living in home:**
Name	Age	Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pregnancy/Birth History:

Mother's age at child's birth: _____
Father's age at child's birth: _____

How many prior pregnancies? _____
How many prior miscarriages? _____

Did the mother receive any regular prenatal care? ☐ Yes ☐ No

Any known health problems of mother during this pregnancy? ☐ Yes ☐ No

If yes, please check all that apply:

☐ Trauma/Accidents	☐ Hypertension/High Blood Pressure	☐ Injury
☐ Anemia	☐ Poor Diet	☐ Poor weight gain
☐ Illness (e.g., flu)	☐ Vaginal bleeding	☐ Excessive weight gain
☐ Gestational diabetes	☐ Preeclampsia/toxemia	☐ Excessive vomiting
☐ Fever/rash	☐ Psychological/Psychiatric	☐ Other

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

Did the mother use any substances during this pregnancy? If so, please specify the amount and frequency.

☐ Alcohol _____

☐ Smoking/Tobacco Use _____

☐ Caffeine _____

☐ Recreational drugs (e.g., marijuana, cocaine) _____

☐ Other medication _____

Delivery was:

☐ Vaginal

☐ Cesarean section (Reason)_____

Delivery was:

☐ On time (37-42 weeks) ☐ Premature ___# of weeks ☐ Late ___# of weeks

Birth Weight: _____ lbs _____ oz.

Apgar scores if known: _____

Was labor prolonged? ☐ Yes ☐ No

How long did the labor last? _____

Were there any difficulties with the delivery? If yes, please describe (e.g., jaundice, fever, transfusion, surgery, etc.).

Did the child need any special care following birth? If yes, please describe (e.g., on a respirator, phototherapy, etc.).

Did the child require additional hospital stay/Intensive Care Nursery stay? If yes, why?

How old was the baby at discharge from the hospital after birth?

Were there any problems in caring for the child during the first few weeks at home? If yes, please describe (e.g., feeding issues).

Did the mother experience a postpartum (after birth) depression? ☐ Yes ☐ No

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

Developmental History:

Was your child's development slower than that of your other children or his/her peers?
☐ Yes ☐ No

At what age did your child:

Motor	**Language**	**Daily functioning**
Sit alone?_____	Point? _____	Dress self? _____
Crawl?_____	Babble? _____	Toilet train? _____
Stand alone?_____	Say single words?_____	Any current toileting accidents?
Walk alone?_____	Combine words?_____	Describe:
Ride a bike?_____	Say three word phrases?_____	_____

Handedness: ☐ Right ☐ Left ☐ Both (Please explain) _____

Did your child require any services (e.g., physical therapy, occupational therapy, speech therapy)? If yes, please identify frequency and dates as well as goals).

Social Functioning:

Does your child get along with other: *Children* ☐ Yes ☐ No *Adults* ☐ Yes ☐ No

Does your child have friends and keep friends? ☐ Yes ☐ No

Please describe:

Does your child understand gestures? ☐ Yes ☐ No

Does your child understand social cues (e.g., read facial expressions, comfort others)? ☐ Yes ☐ No

Is/was your child a toe walker? ☐ Yes ☐ No

Would you describe your child as clumsy or poorly coordinated? ☐ Yes ☐ No

Does your child have increased or decreased responses to sensory stimuli (e.g., overly aversive to sensory stimuli or sensory seeking)? ☐ Yes ☐ No

If yes, please describe.

Does your child demonstrate repetitive/stereotypic movements (e.g., hand flapping)? ☐ Yes ☐ No

If yes, please describe.

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

Past Medical History:

Has your child's vision been checked? ☐ Yes ☐ No

If yes, please state the test date(s) and results.

Has your child's hearing been checked? ☐ Yes ☐ No

If yes, please state the test date(s) and results.

Does your child currently have any medical/neurological/psychiatric diagnoses (e.g., ADHD, asthma)?

If yes, please list current/prior diagnoses.

Has your child ever been hospitalized or operated on? ☐ Yes ☐ No

If yes, please describe. *Please include date/age at the time of admission and reason.*

Has your child ever received any neuroimaging (e.g., CT scan, MRI, EEG)? ☐ Yes ☐ No

If yes, please state when these were obtained and the results.

Does your child present with a history of:

☐ Failure-to-thrive	☐ Diabetes	☐ Impulsivity
☐ Febrile seizures	☐ Loss of consciousness	☐ Hyperactivity
☐ Epilepsy	☐ Asthma	☐ Attention problems
☐ Staring spells	☐ Allergies	☐ Temper tantrums
☐ Lead poisoning/toxic injection	☐ Requiring EpiPen	☐ Nail biting
☐ Meningitis/Encephalitis	☐ Tics/twitching	☐ Head banging

Has your child ever had a head injury or concussion? If yes, please provide the date of the injury, cause of injury, if there was a loss of consciousness, subsequent symptoms, and treatment for each.

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

Has your child ever experienced a seizure or convulsion? ☐ Yes ☐ No

If yes, please provide the following information:

Date of first seizure: _____ **Date of last seizure:** _____

How often do seizures occur? _____

Is there a diagnosis of Epilepsy? ☐ Yes ☐ No

Please describe what happens during a seizure.

Has your child had frequent ear infections? ☐ Yes ☐ No

Does your child suffer from allergies or asthma? ☐ Yes ☐ No

If yes, what allergies does he/she have (e.g., foods, pollen, animals)?

Does your child have any sleep difficulties?

Time to bed _____ **Time he/she falls asleep** _____ **Time he/she wakes**_____

What are your child's current medications? Please include strength (mg of each tablet), dosing (how many tablets, how many times per day), and reason for medication.

Is there any family history of any neurological disorders (e.g., stroke, tumors, brain injury, seizures, Autism spectrum disorder, headaches, developmental delay)? Please specify relative (e.g., maternal aunt, paternal grandfather) and type of disorder.

Is there any family history of learning difficulties (e.g., dyslexia, math disorder, Attention- Deficit/Hyperactivity Disorder)? Please specify relative (e.g., maternal aunt, paternal grandfather) and type of disorder.

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

Is there any family history of psychiatric disorder (e.g., anxiety, depression, bipolar, schizophrenia)? Please specify relative (e.g., maternal aunt, paternal grandfather) and type of disorder.

Educational History:

Name of school: _____

Grade in school: _____

Any grades that were skipped or repeated? _____

Please describe the type of classroom (e.g., general education, self-contained, inclusion):

Please describe the number/types of teachers/aides:

Has your child been educationally classified or evaluated through the school system? ☐ Yes ☐ No

If yes, please list classification and whether services are provided through an Individualized Education Program (IEP) or Section 504 Plan.

What are the areas, if any of difficulty in school (e.g., reading, math, behavior, social)?

What are your child's strengths in school?

Does your child receive any current therapy services at school (e.g., physical therapy, occupational therapy, speech therapy)? **If yes, please describe type and frequency.**

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

Behavior History:

Do you have any concerns for your child's behavior functioning? ☐ Yes ☐ No
If yes, what are your specific concerns?

Do you use any specific discipline methods? ☐ Yes ☐ No
Please describe?

Psychological History:

Has your child participated in therapy before? ☐ Yes ☐ No
If yes, please provide name of therapist(s) and dates of service.

Does your child exhibit any self-injurious behaviors (e.g., head banging)? ☐ Yes ☐ No
If yes, please describe. Please include how often, triggers, and your response.

Has your child experienced thoughts or made expressions of doing harm to him/herself? If yes, please describe. Please include how often, triggers, and your response.

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

Has your child experienced hallucinations (hearing or seeing things that others do not) or delusions? If yes, please describe.

Has your child ever been seen at a crisis center? ☐ Yes ☐ No

Has your child ever participated in any in-patient psychiatric hospitalizations or partial care/residential treatment? If yes, please describe. Please provide the date, length of stay, name of the center/department, and reason for treatment.

Any Additional Comments

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com